Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA, TEXAS 77504

Carrier's Austin Representative Box
#01

MFDR Date Received

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-09-7537-01

August 8, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Undated: "According to TWCC Rule 134.401, the insurance carrier is required to make reimbursement at 75% of audited charges for billed charges that reach the stop-loss threshold of $40,000.00…"

Requestor's Supplemental Position Summary Dated November 3, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment…"

Amount in Dispute: $659,695.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 22, 2005: Liberty Mutual (Wausau) has received your billing for services rendered to the above claimant. Your billing has been reviewed per Rule 133.301 and the fee schedule guidelines, which allow for line item audit. You will be receiving payment along with an explanation of benefits under separate cover…"

Respondent's Supplemental Position Summary Dated September 6, 2005: We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Acts and Rules…"

Respondent's Supplemental Position Summary Dated November 18, 2011: "…The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged…"

Responses Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due

January 11 through 26, 2005	Inpatient Hospital Services	$472,025.70	$0.00
March 15 through 28, 2005	Inpatient Hospital Services	$89,140.01	$0.00
April 5 through 27, 2005	Inpatient Hospital Services	$98,529.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanations of Benefits

- W10 (Z585) – the charge for this procedure exceeds fair and reasonable
- W1 (Z695) – the charges for this hospitalization have been reduced based on the fee schedule allowance
- W1 (Z560) – the charge for this procedure exceeds the fee schedule
- 97 (Z668) – venipuncture charges are included in the global lab fees
- 97 (X094) – charges included in the facility fee

On July 19, 2006, a contested case hearing Decision and Order was issued stating that "The compensable injury on September 29, 2001 extends to and includes rotational thoracoscoliosis which required spinal surgery from T10 to S1. Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and Commissioner's Rules." The respondent appealed the Decision and Order and on October 27, 2006, the hearing officer's decision was affirmed. A separate decision was not issued by the Appeals Panel.

On January 9, 2007, the requestor submitted explanations of benefits along with copies of checks as follows:
January 11 through 26, 2005: $198,213.65
March 15 through 28, 2005: $16,639.37
April 5 through 27, 2005: $43,874.84

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admissions in dispute involve unusually extensive services?
3. Did the admissions in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement for inpatient hospitalization rendered from January 11 through 26, 2005; March 15 through 28, 2005; and April 5 through 27, 2005?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original Medical Dispute Resolution (MDR) submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address

whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanations of benefits issued by the carrier for dates of service January 11 through 26, 2005; March 15 through 28, 2005; and April 5 through 27, 2005 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the Division concludes that the total audited charges for each admission in this dispute exceeds $40,000.

2. The requestor in its original position statement asserts that "According to TWCC Rule 134.401, the insurance carrier is required [to] make reimbursement at 75 % of audited charges for billed charges that reach the stop-loss threshold of $40,000.00." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presumes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

3. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore, the audited billed

charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of the surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in these particular admissions are unusually costly when compared to resources used in other types of surgeries.

4. For the reasons stated above, dates of service January 11 through 26, 2005; March 15 through 28, 2005; and April 5 through 27, 2005 are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…"

     The length of stay from January 11 through 26, 2005 was 10 surgical days and 4 ICU days (the division notes that the itemized statement for the hospital bill dated January 11, 2005 through January 26, 2005 indicates that the private room charge for January 11, 2005 was reversed). Therefore, the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively for a total allowable of $17,420.00.

     The length of stay from March 15 through 28, 2005 was 13 surgical days. The surgical per diem rate multiplied by the length of stay of 13 days results in an allowable amount of $14,534.00.

     The length of stay from April 5 through 27, 2005 was 22 surgical days. The surgical per diem rate multiplied by the length of stay of 22 days results in an allowable amount of $24,596.00.

   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

     Review of the requestor's medical bill dated January 11 through 26, 2005 finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	Screw mono	Exp ant mono screw 5x40mm	4 @ $960.00	$3840.00	$4224.00

	Screw mono	Exp ant mono screw 6x40mm	1 @ $960.00	$960.00	$1056.00
	Screw set exp ant	Exp ant set screw	6 @ $190.00	$1140.00	$1254.00
	Cougar implant	Cougar implant 10mm	2 @ $4835.00	$9670.00	$10,637.00
	Cougar implant	Cougar implant 12mm	1 @ $4835.00	$4835.00	$5318.50
	Cage plif	TI-peek-PLIF	3 @ $2895.00	$8685.00	$9553.50
	Screw click X	TI click X pedicle screw	8 @ $1203.00	$9624.00	$10,586.40
	Screw click X	NA	3 additional units are not supported on the invoice	NA	NA
	Screw mono click X	4.2mm TI click X mono-axial pedicle screw 35mm	6 @ $868.00	$5208.00	$5728.80
	Screw mono click X	4.2mm TI click X mono-axial pedicle screw 40mm	2 @ $868.00	$1736.00	$1909.60
	Screw dual open USS	TI collar for 6mm dual-opening implants	1 @ $150.00	$150.00	$165.00
			TOTAL ALLOWABLE $50,432.80		

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill dated January 11 through 26, 2005 finds that the requestor billed $2484.00 for three units under revenue code 380-Blood General. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 380 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

  A review of the submitted hospital bill dated March 15 through 28, 2005 finds that the requestor billed $2530.00 for two units under revenue code 350-CT scan. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 350 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement dated March 15 through 28, 2005 finds that the requestor billed $330.05/unit for Thrombin USP TOP. The requestor did not submit documentation to support what the cost to the hospital was for this item billed under revenue code 250. For that reason, additional reimbursement for this item cannot be recommended.

The division concludes that the allowable amount for the admission dated January 11 through 26, 2005 is $17,420.00 per diem plus $50,432.80 implants for a total allowable of $67,852.80. The respondent issued payment in the amount of $198,213.65. Based upon the documentation submitted no additional reimbursement can be recommended.

The division concludes that the total allowable for the admission dated March 15 through 28, 2005 is $14,534.00 per diem only. The respondent issued payment in the amount of $16,639.37. Based upon the documentation submitted no additional reimbursement can be recommended.

The division concludes that the total allowable for the admission dated April 5 through 27, 2005 is $24,596.00 per diem only. The respondent issued payment in the amount of $43,874.84. Based upon the documentation submitted no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor for each admission. The requestor in each case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admissions involved unusually extensive and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement for each inpatient admission.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 additional reimbursement for each admission in this dispute.

Authorized Signature

		2013
Signature	Medical Fee Dispute Resolution Officer	Date
		2013
Signature	Executive Deputy Commissioner	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.